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To all Chief Fire Officers

Dear Chief Officer

AIDS

The Fire Brigades Union have expressed concern to us about the possibility of fire brigade personnel contracting AIDS, particularly when they are carrying out resuscitation of victims at fires or road accidents. The following guidance is designed to respond to that concern.

2. Interim guidelines have been issued by the Advisory Committee on Dangerous Pathogens for the HSE and the Health Departments for adoption by those who are directly handling AIDS patients or their specimens. Extracts are enclosed for information. The following brief summary of particularly relevant points may also be helpful. AIDS is a body condition in which there is a reduced ability to combat infection by natural means, which may ultimately result in the death of the person involved. It is caused by a virus, and the incubation period is 4 to 63 months. Known cases have occurred almost entirely in three high risk groups. The most dominant is male homosexuals. The others are intravenous drug abusers, and haemophiliacs who have received AIDS infected blood products during treatment.
3. The principal mode of transmission of AIDS is by anal sex between two males, one of whom already suffers from the condition. A secondary and far less common cause is the introduction into the system of contaminated blood or blood products, by means of direct transfusion or injection. For example, an intravenous drug abuser may inject with a needle previously used by a sufferer from AIDS.
4. The number of those suffering from AIDS or infected with the virus is very small, and AIDS can still be considered as rare. The probability that anyone at work who is not in intimate and regular contact with an AIDS sufferer will contract AIDS from accidental contamination by blood spillage or saliva as in a road accident is extremely remote. The AIDS virus has been recovered from seminal fluid and saliva, but blood is considered to be the main source for transmission of infection. There is no evidence that AIDS has been acquired through casual contact with AIDS sufferers living in the community.
5. In summary, the available authoritative medical advice judges that the possibility of catching AIDS is extremely remote for anyone outside the high risk groups, and that infection from saliva is also highly unlikely. Even if it cannot be discounted absolutely, the risk of infection through mouth to mouth resuscitation is therefore minimal.

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6. Many brigades already carry resuscitation equipment, including resuscitator sets and the Brook's mouth airway, on operational appliances. Paragraph 9 of Fire Service Circular 7/82 confirms that there is no objection to brigades including Brook's airway in the first aid box carried on appliances for the purpose of giving first aid to the public. Similar equipment is carried by ambulance crews, who will normally be expected to assume the lead in dealing with casualties at fires and other incidents. Chief Fire Officers may also like to be reminded that there are other very cheap personal devices on the market, designed to avoid personal contact during mouth to mouth resuscitation. They normally consist of a plastic shield in which is situated a non-retain valve through which air can be breathed into a casualty's mouth, and a polyurethane or similar surround so that physical contact is avoided. Where they do not already make use of such devices, Chief Fire Officers may wish to consider acquiring a small supply for the use of operational crews to supplement the equipment they already carry.

7. Modest additional cost will arise for brigades who do not already issue these devices and who decide to do so or opt to supplement their present stocks. It is expected that fire authorities should be able to accommodate these small additional costs within their existing budgets.

Yours sincerely

GRO-C

ps Sir Peter Darby

INTRODUCTION

1. In view of the concern among clinical and laboratory staff, other hospital workers and researchers who may have contact with AIDS patients or the AIDS agent (now generally accepted as being a retrovirus), ACDP has drawn up the following guidelines which should be adopted whenever AIDS or persistent generalised lymphadenopathy (PGL) is suspected or has been diagnosed.
2. Because of rapid advances in knowledge in this sphere, the Committee should reconsider the advice given in these guidelines 12 months after publication. In the meantime the Health Services Advisory Committee concerned as it is with evaluating the practicalities of implementation should be asked to review them.
3. The ACDP also strongly recommends that where there is an intention to conduct research work which involves the propagation of HTLV III virus or the use of high-titre viable stocks, the Health and Safety Executive should be informed if this has not already been done.

BACKGROUND

4. Certain retroviruses known as human T cell lymphotropic virus - (HTLV III Gallo et al)¹ and lymphadenopathy associated virus (LAV Barre-Sinoussi et al)² have been recovered from patients with AIDS. These two agents which are now believed to be identical* have also been isolated from patients with PGL, haemophiliacs and apparently healthy male homosexuals.
5. Further to this, evidence of infection as shown by the presence of antibody to HTLV III has been demonstrated in the following groups in the UK:

*Footnote: For the purposes of these guidelines HTLV III is taken to be synonymous with LAV.

1 Science 224 May 4 1984

2 Science 220 May 20 1983

PREFACE BY THE
HEALTH & SAFETY
EXECUTIVE AND
THE HEALTH
DEPARTMENTS

1. The Advisory Committee on Dangerous Pathogens (ACDP) were asked by the Health Departments and the Health and Safety Executive for advice on the measures which should be taken to safeguard the health and safety of people who because of their work come into direct contact with patients with the Acquired Immune Deficiency Syndrome (AIDS) or specimens from them.

2. With the emergence of this serious and newly recognised disease, which is not yet fully understood, it is essential that those who might be occupationally exposed are provided with safeguards which take account of the hazard. These guidelines represent the considered view of the Committee at this time of how the balance between hazard, the risk, and appropriate protective measures should be weighed.

3. Rapid advances are however taking place in knowledge of the disease and the agent responsible for it, and these guidelines are therefore interim. The Committee will keep under continuous review any new information published in the scientific press. They will also welcome evidence or comments from health care workers, from researchers in the field or other interested parties, which will allow them to re-assess the measures they have recommended.

4. In presenting these guidelines, the Committee made two further points. First they recommended that those wishing to undertake research with viable HTLV III virus should notify the HSE. Second that with the likely increase of the number of cases of AIDS, Health Authorities might like to consider the designation of laboratories equipped to carry out necessary investigations at the appropriate level of containment.

5. Anyone wishing to comment or provide information should write to the Secretariat of the ACDP at either of the addresses shown below.

Health & Safety Executive
MD A2
25 Chapel Street
London NW1 5DT

Department of Health & Social Security
MED-SEB Room 1004
Hannibal House
Elephant & Castle
London SE1 6TE

<u>Categories</u>	<u>Number tested</u>	<u>% positive</u>
AIDS patients	31	= 97
PGL patients	124	= 89
Symptomatic homosexuals	69	= 59
Contacts of AIDS or PGL	36	= 42
Homosexuals at risk	308	= 17
Heterosexuals from genitourinary clinics	35	= 0
Haemophiliacs who have received pooled clotting factors	184	= 34
Intravenous drug abusers	269	= 1.5

Over one thousand unselected blood donors were also tested for antibody but none was positive. (Cheingsong-Popov et al)¹

6. The present situation with regard to the number of established cases of AIDS in the United Kingdom (and in the USA for comparison paragraph 7) is illustrated below. The clinical criteria used to make the diagnosis of AIDS are those provided by CDC and now adopted almost worldwide

The first formal report of AIDS in the UK appeared in 1981 (Lancet December 12th). Since that time 88 cases have been identified (up to October 1984) one of which was diagnosed retrospectively as having occurred in 1979. Of the 88 reported cases 37 have since died.

Cases may be grouped according to their prime recognisable condition.

¹ Lancet September 1, 1984

Kaposi's sarcoma (KS)	30
Pneumocystis carinii pneumonia (PCP)	32
KS plus PCP	5
Other opportunistic infections	20
Cerebral lymphoma	1

88 CDSC October 1984

7. Of the 88 cases reported by October 1984, over 75 per cent were male homosexuals while the remainder were patients with direct or indirect contact with central Africa, recipients of pooled clotting factors and a small group with no recognised risk factor. The number of cases in the USA now exceeds 6,000 which, even allowing for population differences represents an incidence rate much higher than that in any other country. There are several hundred cases in Europe, the largest numbers being recorded in France and West Germany.

8. If the trend in the UK follows that seen in the USA we can expect an exponential increase in the number of cases of clinical AIDS diagnosed. Furthermore the serological studies referred to above seem to indicate that whereas the most severe outcome of infection with HTLV III is certainly AIDS, it cannot be assumed that all infections with this virus will necessarily lead to this disease, although the possibility cannot be ruled out.

9. Experience in the USA indicates that there is no evidence of the disease having been acquired through casual contact with persons with AIDS living in the community. Neither is there any satisfactory evidence of clinical AIDS developing in hospital or laboratory personnel through occupational exposure despite contact with over 6,000 affected patients and their specimens. However at the present time it is not possible to identify with certainty at which stage or stages of HTLV III infection the virus is transmissible nor are all possible routes of infection known. Until more is discovered about the natural history of HTLV III we cannot assess the true risk to laboratory and hospital staff. Consequently a clinician who has grounds to believe that a patient has been infected must ensure that appropriate warnings of hazard are always given. At the same time the doctor should avoid raising the fear of AIDS in the patient.